

SIGNATURE REQUIRED
YOU MUST COMPLETE THIS PAGE AND RETURN



EXEMPLARY PROVIDER SATISFACTION MEASURE®

Patient Name: _____ Patient Phone: _____

New Existing Equipment: _____ Date Received: _____
(equipment received)

ACCESS, DELIVERY AND SERVICE

	YES	NO	N/A
1. Equipment/Supplies was delivered in a timely manner.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Equipment/supplies was ready for patient use upon delivery.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Received and understood instructions on proper application and use of equipment/supplies.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Feel confident to operate/use equipment/supplies.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Received info on my Rights & Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Response to my questions, problems, concerns were addressed in a timely manner.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Satisfied with the equipment or supplies.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Satisfied with the service. Would recommend to others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments: _____

Employee: _____
(Peak Medical Supply represenatative who helped you - if applicable)

Signature: _____ Survey Date: _____

Please sign above and mail back to Peak Medical Supply in the included envelope - or at the address below if supplied envelope has been lost or damaged:

Peak Medical Supply
450 Business Highway 64, Unit 3
Hayesville, North Carolina, 28904

To digitally sign all "signature required" documents in this packet, please visit:
www.PeakMedicalSupply.com/eSign